R. Lawrence Siegel, M.D. Ph.D.

ALLERGY
PATIENT HISTORY FORM

Please answer the following questions with regard to your experiences and do NOT base your answers on previous skin tests (except where asked for). Please print, type, or circle those items which apply, and remember to bring this completed form and any medicines you are taking with you for your appointment.

Patient's Name_____ Age_____ Sex_____

Place of birth_____ How long have you lived in this area?_____Permanent Resident?_____
If not, where is your home?_____
Do you have symptoms at home?_____
I am (better) (worse) in this area.
Is your home: urban rural farm.
PROBLEMS for which we are seeing you: (Please list in chronological order of onset).

PROBLEM:	Age of onset	Where living at that time
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Which of the following apply WHEN YOU HAVE SYMPTOMS? (please circle).

General: Sinus, frequent colds, fatigue, poor appetite, dizziness, nervousness, weight loss, chills,fever

Headache: Where: front, back, top, sides, right, left, behind eyes, above eyes, below eyes. Type: Sharp, dull, aching, throbbing, pressure, better with sleep, wake up from sleep.
Associated with: stuffy nose, tension, vomiting, spots before eyes, trouble seeing.
Frequency_____ times per_____
Cause: migraine, food, sinus, tension, drugs.
Movement causes "shifting" in head.

Skin: Rash, hives, eczema, blisters, itching, swelling, burning, redness, dandruff, athlete's foot.
Location on body_____. Worse (after eating, after drugs, during menses, after exercise, after shower, other_____).

Eyes: Tearing, itching, burning, pain, redness, discharge (type: watery, thick, yellow), puffiness, blurred vision, sensitivity to light, dark circles under eyes.

Ears: Pressure, itchiness, drainage, bleeding, impaired hearing, deafness, recurrent infections, popping, ringing.

Nose: Trouble smelling, stuffiness, runny, itching, sneezing, snoring, polyps, post nasal drip, bleeding, trouble breathing, deviated septum, broken nose, sniffling.
Mucous is: thick, thin, clear, watery, yellow, green, brown, bloody.
Amount per day: teaspoon, tablespoons, 1/2 cup, more

Tongue: Swollen, sore, itching, coated, trouble tasting.

Mouth: Itching of roof, repeated tonsillitis, morning sore throat, bad breath, swollen lip, trouble swallowing, mouth breathing, frequent throat clearing, hoarseness, throat swelling, throat itch, throat tickle, painful teeth.

Cough: Deep, dry, loose rattle, daytime, nighttime, exertional, constant, emotional, after eating.
Phlegm is: thick, thin, clear, watery, yellow green, brown, bloody.
Amount of phlegm per day: none, teaspoon, tablespoon, 1/2 cup, more.

Chest: Shortness of breath, wheeze, pain, tightness, cough, cough then wheeze, trouble breathing on exertion, trouble sleeping, emphysema, bronchitis, TB, recurrent pneumonia, sharp pain with breathing.

Stomach: Vomiting, gas, cramps, belching, diarrhea, mucous in stool, blood in stool, worse after eating what foods_____.

Menses: (Females only) Are you pregnant? Yes No.
Taking birth control pills? Yes No I.U.D. Yes No. Are you post- menopausal? Yes No.

Urine: Pain, burning, frequent, itching, bedwetting, Recurrent infections.

Food Allergies: What foods are you allergic to?_____
_____

Insect Venom Allergies: What stinging insects are you allergic to?_____

SYMPTOMS ARE MOST SEVERE

Time: Upon arising, Morning, Afternoon, Evening, Night
No difference, Any time.

Day of the week: Weekdays, Weekends, No difference.

Most severe months: Jan. Feb. Mar. Apr. May June July
Aug. Sept. Oct. Nov. Dec. All year

Locations: Indoors, Outdoors, Work, School, Home (bedroom, den, living room, bathroom, workshop, kitchen garage, anyplace at home), car, boat, library, beauty shop, department stores, no difference.

Does travel to other geographical areas make you better or worse (please detail)_____

Most symptom free months: Jan. Feb. Mar. Apr. May June July Aug. Sept. Oct. Nov. Dec. None
Are there places where you are free of symptoms? Beach, City, Farm, other_____

HOW OFTEN do you have symptoms? Present, most of the Time, comes and goes. If it comes and goes, how often? _____. How long does it last on the average?_____

CONDITION is: Getting better, stays the same, getting Worse. Have you been or are you on cortisone type drugs? Yes No. If yes when?_____ For what?_____ Drug or dose_____ Length of time_____.
In the past year, how many days of work/school have you missed because of this problem?_____.

What SPECIFIC THINGS do you know of which cause or worsen symptoms?_____

What type of pillow do you use? Feather Foam Dacron Other How old is it?_____ What type of blanket do you use?_____ What type of mattress do you use? Foam Innerspring Waterbed How old is it?_____
Do you have carpeting? Yes No In the bedroom? Yes No Type_____ What kind of rugpad is under your Carpet?_____.
Is a fabric softener used in the laundry? Yes No Brand?_____

Do you in a: House Apartment Condo Mobile home. How old_____. If a house, is it: Frame Concrete block Other_____.
What items are in the bedroom? Books, Blinds, Stuffed animals Pets, Carpets, Curtains, Stored clothes, Upholstered Furniture.
Is there mold/mildrew growing anywhere in the house? Yes No Where?_____

Animals: Which animals bother you? (Bird, cat, dog, Horse, cattle, gerbil, hamster, rabbit, other_____)
Do you have any pets? Yes No. What kind?_____
Are they kept in the house? Yes No. Allowed in the bedroom? Yes No.
Do you have indoor plants? Yes No
Type_____.

What type of heating/air-conditioning? (central, wall Units, fans) Does air conditioning make you: Better No Difference Worse. Does heating make you: Better No difference Worse.

Please CIRCLE specific items which AFFECT YOU BY CAUSING SYMPTOMS:
Irritants: Cleanser, detergent, cooking odor, perfume, Powder, tobacco smoke, other smoke, moth balls, fumes, paint, wax, glue, insect spray, fertilizer, room deodorant, chemical_____, insect repellants, pollution, dust (sweeping, vacuuming), other_____.

Toiletries: Scented soaps, other soaps, shampoo, shaving-cream, after shave, hair spray, spray deodorant, hair tonic, hair dye, hand cream, make-up, tooth paste, denture cream, mouth wash, nail polish, nail polish remover, hand creams, lipstick, mascara, foundations, other_____

Foods: Milk, cheese, all dairy products, seafood, nuts, chocolate, whiskey, wine, beer, juices, corn, pork, egg, spices, tomatoes, strawberries, wheat, citrus, hot drinks, cold drinks, soybean products, other_____
How much milk do you drink in a day?_____
How much alcohol do you drink in a day?_____

Environment: Hot weather, cold weather, humid, dry, smog, fog, pollution, air conditioning, heat being on, rain, change in temperature, wind, change in weather, mold, smell of mildew, bright sunlight, other_____.

Clothing: Wool, Silk, dry cleaned clothes, starched clothes, permanent press, shoes, other_____

Contactants: Poison Ivy or Oak, cut grass, cut flowers, plants, Christmas trees, plastic, fiberglass, rubber, over stuffed furniture, shoe polish, jewelry, newspapers, skin preparations, skin medicines, N.C.R. paper, other_____

Emotions: Does emotional upset, stress, tension, excitement, or nerves cause or aggravate your symptoms? Yes No
Drugs: ARE THERE ANY DRUGS TO WHICH YOU ARE ALLERGIC Yes No

DRUG	REACTION	DATE
_____	_____	_____
_____	_____	_____

Have you ever had a bad reaction to x-ray dye? Yes No
Date_____.
Have you ever had a bad reaction to Penicillian? Yes No
Date_____.
Have any medications ever caused wheezing? Yes No
Which?_____.
Do you use ASPIRIN or ASPIRIN CONTAINING medicines? Yes No
Which ones?_____How often_____
Do these ever cause you to wheeze, cough, or be short of breath? Yes No.
Do sulfites or other preservatives bother you? Yes No
Do you use: Laxatives Yes No How Often_____ Brand_____
Sleeping Pills Yes No How Often_____ Brand_____

Do any of the following ever cause you to cough, wheeze, or be short of breath? Exercise, laughing, coughing, hiccupping, foods, eating or drinking, none. Explain:
_____
Did you have pneumonia before the age of 2 years? Yes No
Have you been hospitalized for pneumonia? Yes No
Date_____ Are your symptoms accompanied by fever: Never, occasionally, usually, always.
Do you smoke? Yes No What_____ Amount_____
For how long_____Are you bothered by smoke? Yes No
What is your occupation?_____
Any vapors, smells, or chemicals which trouble you? Yes No
Explain please_____
What is your spouse's occupation?_____
What are your hobbies?_____
Do they provoke symptoms?_____
Average number of hours of sleep per day:_____
What exercise and how many hours per day:_____

THERAPY
What DRUGS have you been on FOR YOUR SYMPTOMS and how Effective were they?

Drug	Effectiveness	Drug	Effectiveness
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Do you use nasal sprays? Yes No Brand(s)_____
How often?_____ For how many years_____
Do you use inhalers for asthma? Yes No Brand(s)_____
How often?_____ How long does one last_____
What are other things have you done to get relief and how effective were they?_____

Have you previously consulted an allergist? Yes No If yes, Name_____Address_____
Were skin tests done? Yes No. Positive reactions to:_____
_____
Were you placed on injection therapy? Yes No How long?_____
Date of last injection_____ Did injections help?___
What other advice were you given?_____

PAST HISTORY (Please circle items which apply to you or answer question).
As an infant: Cesarean section, normal delivery, birth weight_____, premature, Rh problems, colic, rash, eczema, bowel obstruction, breast fed, difficulty with first B.M., bottle fed_____, solid foods started_____, feeding difficulties, pneumonia, abnormal development, chronic vomiting or diarrhea, bronchiolitis.

Have you ever had: food allergies, frequent colds or ear infections, chronic cough, recurrent pneumonia, eczema, bronchitis, sneezing fits, croup, hay fever, asthma, wheezing, hives, chronic vomiting or diarrhea.
Any serious illnesses in the past_____

Any medical problems at this time other than allergies_____
_____

Are you taking any medications at this time other than Allergy medicines?

Drug	Dose	For how long	Drug	Dose	For how long
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Have you ever had any operations? (please give dates)
_____

Any other hospitalizations?_____

Any serious injuries?_____

Are you immunizations up to date? Yes No Date of last Tetanus immunization_____. Date of last tuberculin (T.B.) test_____. Positive negative

FAMILY HISTORY

Who in your family has or has had the following (please include maternal and paternal grandparents, parents, brothers, sisters, children, aunts, uncles, and cousins.

Hay Fever_____
Sinus Trouble_____
Asthma_____
Bronchitis_____
Sneezing fits_____
Eczema_____
Hives_____
Migraine_____
Emphysema_____
Cystic fibrosis_____
Tuberculosis_____
Sudden “swelling”_____
Sudden unexplained deaths_____

Number of brothers and sisters_____

Number of children_____

Date of last chest x-ray_____

Date of last sinus x-ray_____